SECTION B

INDIVIDUAL REHABILITATION SUPPORT

SOUTH CAROLINA
Department
OF
Disabilities
AND
Special Needs

SECTION B: INDIVIDUAL REHABILITATION SUPPORT SERVICES

B-1 Definition

Individual Rehabilitation Supports (RS/I) are therapeutic interventions and assistance to improve a condition or to promote/retain an optimal level of functioning in a person with a disability. The scope of Individual Rehabilitation Supports is sufficient to develop enhanced capacity for successful community living (e.g. greater independence, self-direction, and participation in community activities) and thus reduce the degree of impairment and/or dependency. Individual Rehabilitation Supports (RS/I) services may be provided in **the individual's home, natural environment and/or other appropriate community settings**. This option is provided on an individually determined schedule and focuses on individual skills, which promote interactions with people who do not have disabilities.

Individualized goals and objectives are developed based on assessed and prioritized needs in the areas of:

- Self-Care Skills (ex. eating, toileting, dressing, hygiene, grooming, etc.).
- Community Living Skills (ex. getting from place to place throughout the community (transportation); shopping and purchasing goods and services; use of public buildings/services, financial management, understanding and avoiding health and safety hazards; accessing services (non-emergency and emergency); learning and using problem-solving strategies; preparing meals; operating appliances; use and maintenance of adaptive devices; mobility, etc.).
- Psycho-Social Skills (ex. skills to support a positive impact on self or others; self-determination skills; understanding and practicing responsible behavior; protecting self from victimization; advocacy skills; exercising legal rights; obeying rules/laws; developing and maintaining natural supports, receptive and expressive communication skills; recreation or leisure understanding and participation, etc.).
- Medication Management / Symptom Reduction Skills (ex. self-administration of medication or treatment; basic identification and monitoring of medication side effects; basic understanding how one's diet/exercise effects medication outcomes; basic understanding a health condition; coping strategies that help to manage symptoms of mental illness including relaxation, hallucination control exercises, and cognitive strategies for delusions, etc.).

These goals and objectives are included in a treatment plan developed by the consumer with the Lead Clinical Staff (LCS) or Life Skills Specialist, and others as appropriate.

B-2 Eligibility Requirements

To be eligible for Individual Rehabilitation Supports the consumer:

- Must be eligible for services through SCDDSN [MR/RD, Autism, or HASCI].
- **Must be Medicaid eligible.**
- Must have the Medical Necessity confirmed by a Licensed Practitioner of the Healing Arts.
- **May** receive RS/I if residing in a Community Training Home, Supervised Living Program or Community Residential Care Facility as long as other eligibility requirements are met.
- **May** receive RS/I if enrolled in the **Community Long Term Care (CLTC) Elderly and Disabled Waiver**. Notification to CLTC case manager must be made prior to service provision.
- Must be authorized to receive the service by a Service Coordinator or Early Interventionist and approved by the Home Board Provider.
- Must not be enrolled in the MR/RD Waiver.
- Must not reside in an ICF/MR or Nursing Home.

B-3 Referral Process

1. The consumer's Service Coordinator or Early Interventionist must complete the Rehabilitation Supports Screening (RS Form 1) to determine if the consumer has needs that can be addressed through Rehabilitation Supports.

2. When it is determined the consumer has needs that can be addressed through Rehabilitation Supports and the consumer chooses to participate, the consumer's Service Coordinator or Early Interventionist must make a referral to the Individual Rehabilitation Supports Lead Clinical Staff or Life Skills Specialist.

The following documents must be included with the referral:

- Any documents to support the consumer's need for the service (ex. Single Plan, psychological evaluation, social summary, etc.)

- A copy of the Rehabilitation Supports Screening (*RS Form 1*)

B-4 Service Allocation

When the Lead Clinical Staff receives the Rehabilitation Supports Screening (*RS Form 1*), he/she must have the Medical Necessity Statement (*RS Form 2*) completed/approved by a Licensed Practitioner of the Healing Arts and place the original form in the consumer's record.

NOTE: A Licensed Practitioner of the Healing Arts includes: physician, licensed psychologist, licensed social worker, licensed registered nurse with a masters degree in nursing, licensed nurse practitioner, licensed doctor of Osteopath, licensed professional counselor (masters or doctoral level), or licensed family therapist (masters or doctoral level).

When approved by the Licensed Practitioner of the Healing Arts, and an opening is available, the Lead Clinical Staff will:

1. Notify the consumer's Service Coordinator or Early Interventionist within ten (10) business days, by returning a completed (e.g., bottom section) copy of the Rehabilitation Supports Screening *(RS Form 1*). The original should be placed in the consumer's record; and

2. Insure that the Service Tracking System is updated within two (2) business days to reflect that the consumer is/will be receiving Individual Rehabilitation Support Services. Refer to the DDSN "Service Tracking System Reference Manual" for instructions.

When an opening is not available, the Lead Clinical Staff will:

3. Notify the consumer's Service Coordinator or Early Interventionist within ten (10) business days, by returning a completed (e.g., bottom section) copy of the Rehabilitation Supports Screening *(RS Form 1*). The original should be placed in the consumer's record;

1. Insure that the Service Tracking System is updated within two (2) business days to reflect the consumer is on the waiting list for Rehabilitation Support Services; and

2. Maintain documentation to denote the consumer's name and date he/she was placed on the waiting list.

NOTE: Cross Reference First Health Key Indicator G2-35.

NOTE: For questions relating to entering data on the STS, telephone 803-898-9441.

B-5 Reporting Requirements

For complete reporting requirements, reference the: DDSN Finance Manual; Service Units Reporting & Billing; Individual Rehabilitation Supports; Section 10.15. and DDSN/Provider Contract (Family Support Services), Report of Services (*RS Form 9*).

NOTE: Cross Reference First Health Key Indicator G2-33.

B-6 Termination

Termination from Individual Rehabilitation Support Services may occur when the consumer:

- No longer meets Individual Rehabilitation Support Services eligibility criteria;
- Voluntarily withdraws;
- No longer needs Rehabilitation Supports.
- Has not received services for two (2) consecutive calendar months. (For example: a person who does not receive services for the month of January or February may have services terminated March 1)

When a termination occurs, the Lead Clinical Staff or Life Skills Specialist must:

1. Complete the Notice of Termination (*RS Form 6*), and send the original form to the consumer accompanied by the appeal procedure, and a copy to the consumer's Service Coordinator or Early Interventionist; and when appropriate a copy to central office HASCI administrator.

2. Maintain a copy of the Notice of Termination (*RS Form 6*) in the consumer's record; and

3. Insure that the Service Tracking System is updated within (2) two business days to reflect the consumer no longer receives Individual Rehabilitation Support Services. Refer to the DDSN "Service Tracking System Reference Manual" for instructions.

NOTE: Cross Reference First Health Key Indicator G2-35.

NOTE: *For Head and Spinal Cord Injury (HASCI) Division Only. The Statement for Declining Services (RS Form 8) is used when a HASCI consumer does not want to participate in the Rehabilitation Supports Program and the consumer has not received any units of service. The Life Skills Specialist must document in the service notes the explanation of the statement for declining Rehabilitation Supports with the consumer and the reason the consumer chose not to participate in the Rehabilitation Supports Program.*

B-7 Lead Clinical Staff or Life Skills Specialist

Responsibilities:

Provides initial and ongoing monitoring to insure compliance as outlined in this manual (Section E), and supervises direct support staff.

Qualifications:

Education:

The Lead Clinical Staff or Life Skills Specialist provides supervision of staff implementing the service and evaluates and assesses the consumer's needs. The LCS or LSS must have experience in working with or managing programs for persons with Mental Retardation, Autism, Head or Spinal Cord Injury or related disabilities/similar disabilities or in the mental health field. The following professionals qualify as Lead Clinical Staff:

1. Psychologist- A holder of a Doctoral degree in Psychology from an accredited university or college.

2. Registered Nurse- a registered nurse licensed in South Carolina who has a minimum of one (1) year of experience.

3. Mental Health Counselor- A holder of a Doctoral or Masters degree from an accredited university or college in a program that is primarily psychological in nature (e.g., psychology, counseling, guidance, or social science equivalent).

4. Licensed Master Social Worker- A holder of a Masters degree from an accredited university or college who is licensed by the South Carolina Board of Social Work Examiners.

5. Mental Health Professional Masters Equivalent- A holder of a Masters degree in a closely related field that is applicable to the bio/psycho/social sciences or to treatment of the mentally ill; or a Ph.D. candidate who has bypassed the Masters degree but has sufficient hours to satisfy a Masters degree requirement; or a professional who is credentialed as a Licensed Professional Counselor.

6. Clinical Chaplin- A holder of a Master of Divinity degree from an accredited theological seminary who has one (1) year of Clinical Pastoral Education that includes provision of supervised clinical services.

7. Child/Adult Service Professional- A holder of a Baccalaureate degree in Psychology, Social Work, Child Development, or a related field from an accredited university or college; or a holder of a Baccalaureate degree in another field who has advanced training in one or more of the above disciplines. A minimum of three (3) years of experience in direct child/adult services to people with disabilities is required, along with extensive knowledge of and regular training in the needs of children/adults with disabilities.

8. Licensed Baccalaureate Social Worker- A holder of a Baccalaureate degree from an accredited university or college who has been licensed by the South Carolina State Board of Social Work Examiners.

Age:

Must be at least 21 years of age.

Training:

Must demonstrate competency in training requirements as outlined in DDSN Policy 567-03-DD.

Criminal Background Check:

Must pass a criminal background check that includes an initial SLED check (within 6 months prior to employment). "Pass is defined as, the Lead Clinical Staff must never have been convicted, pled guilty or nolo contendere for abuse, neglect, mistreatment or exploitation of a child or a vulnerable adult.

Health:

Must pass an initial physical health exam (within 6 months prior to employment) conducted by a physician, to include a tuberculosis exam as stipulated in DDSN Policy 603-06-PD. Documentation of the physical health exam must show that the staff is in reasonably good health, with no signs of contagious disease, which would place the consumer and other personnel at risk, and that staff is capable of aiding in the activities of daily living.

Transportation:

Must maintain a valid driver's license and use an insured vehicle if driving is required as part of the job.

B-8 Direct Support Staff

Responsibilities:

Responsible for implementing the consumer's Treatment Plan.

Qualifications:

Education:

Must demonstrate communication skills with the ability to effectively read, write and speak English.

Age:

Must be at least 18 years of age.

Training:

Must demonstrate competency in training requirements as outlined in DDSN Policy 567-03-DD, or meet the minimum qualifications as outlined in Section D- Home supports: [Staff Certification] Effective October 1, 2001.

Criminal Background Check:

Must pass a criminal background check that includes an initial SLED,(within 6 months prior to employment). "Pass is defined as, the direct support staff must never have been convicted, plea guilty or nolo contends ere (in any jurisdiction) for abuse, neglect, mistreatment or exploitation of a child or a vulnerable adult.

Health:

Must pass an initial physical health exam (within 6 months prior to employment) conducted by a physician, to include a tuberculosis exam as stipulated in DDSN Policy 603-06-PD**.** Documentation of the physical health exam must show that the staff is in reasonably good health, with no signs of contagious disease, which would place the consumer and other personnel at risk, and that staff is capable of aiding in the activities of daily living.

Transportation:

Must maintain a valid driver's license and use an insured vehicle if driving is required as part of the job.

B-9 Consumer Assessment

The LCS (or designee) is responsible for completing a comprehensive assessment of the consumer's strengths and needs in the areas of:

Personal care: bathing, dressing, grooming, toileting, hygiene, dental care, and treating minor illnesses/wounds.

Cognitive/independent living skills: planning, organizing, and strategies to function as independently as possible on a daily basis; can include skills training in areas of memory, concentration, problem-solving, and self determination.

Medication management and symptom reduction: taking medications, purchasing/maintaining, storing, and identifying medications and conditions for which it is taken.

Health and nutrition: maintaining good health, preventing secondary conditions and following a prescribed diet.

Self-esteem: identify own values, needs, interests, and physical limitations.

Coping skills: managing stress, managing own behavior.

Personal responsibility and self-direction: setting personal or career goals, setting and maintaining a personal schedule, using an alarm.

Social Skills and positive interactions with others: communicating with other people, making appropriate comments and asking appropriate questions, maintaining personal space, staying focused on a topic/discussion.

Community living and peer relationships: money, financial, home care, safety, and contacting/associating with people in the community.

The assessment must be completed or updated:

- No later than twenty (20) business days after the consumer has been awarded the service;
- Prior to developing the Treatment Plan;
- Annually [e.g. within 365 business days from initial date], and
- As needed to ensure accuracy, reliability and validity

NOTE: The DDSN Day Service Assessment (found in Section F, of this Manual) may be used as the assessment tool to assess strengths and needs in following areas: Self-Care, Community Living, Psycho-Social and Medication Management / Symptom Reduction Skills. Service providers using optional or additional assessment instruments must be sure that, as a minimum, each of the areas on this assessment instrument are included in their assessment.

***NOTE**: For consumers served through HASCI, the HASCI Individual Rehabilitation Supports Assessment must be completed in lieu of the aforementioned assessment and must be completed by the Life Skills Specialist.*

B-10 Treatment Planning

The Lead Clinical Staff or Life Skills Specialist is responsible for:

- Arranging a treatment plan meeting to be held no later than twenty (20) business days after the consumer has been awarded the service, and annually (e.g. within 365 business days from the "Date Services Begin", and within 365 business days thereafter);

- Notifying all participants chosen by the consumer. Since the results of the planning process will guide the development of the consumer's treatment plan, it is paramount that the consumer, and individuals who know the consumer best to be involved in the planning process; and this information should be documented in the consumer's record.

- With the meeting participants, the schedule for service delivery and frequency of services must be determined and included on the treatment plan. The Treatment Plan must also reflect the date services are to begin. This date must be selected by the consumer and staff and must be the same date or a date later than the Treatment Plan date. The Plan must be signed and dated by the LCS and the consumer. Copies of the plan must be forwarded to the consumer and the consumer's Service Coordinator/Early Interventionist. The forwarding of these copies must be documented in the service notes.

B-11 Treatment Plan Development

A treatment plan must be developed as outlined in (*RS Form 3B.1*). The Lead Clinical Staff or Life Skills Specialist must assure that each treatment plan is:

1. Meaningful (e.g., relating to assessed needs and goals that were prioritized by the consumer);

2. Functional (e.g., positively impacts the consumer's capacity for successful community living and thus reducing the degree of impairment, dependency and/or psychiatric symptomology); and

3. Formulated no later than twenty (20) business days after the consumer has been awarded the slot, and updated annually (e.g. within 365 business days from the "Date Services Begin", and within 365 business days).

Objectives must target one of the nine areas(defined in B-9): Personal care, Cognitive/Independent Living Skills, Medication management and symptom reduction, Health and nutrition, Self-esteem, Coping skills, Personal responsibility and self-direction, Social Skills and positive interactions with others, and Community living and peer relationships.

Objectives must be:

1. Written in a single behavioral outcome.

   For each discrete skill to be learned, a separate objective is assigned. For example, "Mary will cross the street and locate community resources" are two separate skills and, therefore, must be stated in two separate objectives. For example, "Mary will cross the street" and "Mary will locate community resources".

2. Assigned a projected completion date.

   The date is based on when the objective is likely to be completed based the consumer's rate of learning. This date is used as a trigger to evaluate whether or not the consumer's progress is sufficient to warrant a revision to the objective.

3. Written in terms that provide measurable indices of performance.

   The objective is stated in a manner, which enables staff to clearly identify the target behavior when it is being displayed and how to determine successful achievement of the objective. For example, "Mary will independently locate 4 of 7 community resources."

4. Assigned a method to be used.

   Provides clear directions to any staff working with the consumer on how to implement the training objective. For example, if a consumer is learning to identify coins, the training program methodology must specify for the staff how the training is to be conducted (i.e. present a penny, nickel, dime and quarter and ask the consumer to name the _____; present only one coin at a time and ask the consumer to name the coin that is presented; present two different coins at a time and ask the consumer to name one of the two presented and continue until all coins have been presented and named in this manner). Additionally, this methodology must specify any other information that would be important and would affect the training such as hearing loss, visual impairment, limited use of extremities, etc.

5. Assigned a schedule for use.

   The training program provides clear directions to any staff working with the consumer about when the objective must be implemented.

6. Assigned a type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.

   The training program provides clear directions to any staff working with the consumer about the type and frequency of data to be recorded. The data collection system is directly related to the outcome stated in the objective. For example, if the criteria in the consumer's objective specified some behavior to be measured by "accuracy," or "successes out of opportunities," then it would not be acceptable for the prescribed data collection method to record "level of prompt." Examples of a few data collection systems include, but are not limited to, level of prompt, successful trials completed out of opportunities given, frequency counts, frequency sampling, etc. Staff must collect data with enough frequency and content to measure the consumer's performance toward the targeted objective.

NOTE: Cross Reference First Health Key Indicator G2-29a.

B-12 Treatment Plan Implementation

As soon as the Treatment Plan has been formulated, the Lead Clinical Staff must ensure staff implements the Treatment Plan:

- Correctly:
- Consistently;
- In a safe, efficient manner in accordance with accepted standards of best practice;
- By maintaining training data on the Progress Summary Note (Daily) form (*RS Form 4B*) for each consumer, and reporting the service on the same form; and
- Completing a Progress Summary Note (Monthly) form (*RS Form 4B*) monthly for each consumer to ensure goals, objectives, and activities are pertinent to the progress of the consumer.

B-13 Monitoring

The frequency of monitoring is based on the needs of the consumer and findings during previous monitoring, but at least monthly. When monthly monitoring indicates any problems, more frequent monitoring may need to be performed to identify and eliminate the problem.

The most valid and reliable sources of monitorship include: observation, interview and record review.

Progress Summary Note:

Daily documentation must be recorded on the Progress Summary Note (Daily) (*RS Form 4B*).

A narrative summary of the month's progress, lack of progress towards goals must be documented on the Progress Summary Note (Monthly Summary) (*RS Form 4B*). The activities of the consumer and staff, the involvement of the staff in the provision of service and the consumer's overall health status and the status of community living skills should be documented in the summary.

Instructions for completing the Progress Summary Note are included on Page 1 of 3 of RS Form 4B.

NOTE: Cross Reference First Health Key Indicator G2-32 and G2-33.

Service Notes:

Service notes should be used to document receipt of referral, service allocation or addition to waiting list, Medical Necessity Statement completion, STS verification, assessment and treatment plan completion, and termination. Other situations may require documentation in service notes including treatment plan amendment, changes in condition, etc. Normal daily documentation should be completed on the Progress Summary Note (Daily) form.

Six Month Review:

Six (6) months after the annual treatment plan is formulated **(regardless of amendments to the treatment plan),** the Lead Clinical Staff or Life Skills Specialist must evaluate the consumer's treatment plan to assess:

- The continued appropriateness and effectiveness of the goals/objectives identified within the treatment plan in meeting the needs and goals of the consumer;
- Other issues pertinent to the functioning of the consumer;
- The specific need for the consumer to continue receiving rehabilitation support services.
- **Every six (6) months thereafter (except when the six-month coincides with the annual review).**

Documentation of the review must be recorded on the **Treatment Plan with a signature.**

NOTE: Cross Reference First Health Key Indicator G2-31.

Administrative Monthly Meeting:

The Lead Clinical Staff must also attend and chair a staff meeting at least monthly, during which time administrative and consumer treatment issues are considered. Documentation of the meeting should reflect:

- Topics reviewed (ex. Risk Management per DDSN Policy 100-26-DD; Quality Assurance per DDSN Policy 100-28-DD; DDSN Policy 105-01-DD Consumer Review Outline, etc.);
- Actions/Recommendations;
- Date of meeting; and
- List of participants.

B-14 Treatment Plan Amendments

The Lead Clinical Staff or Life Skills Specialist is responsible for amendments to the consumer's Treatment Plan (Form 3B.2) in a timely manner when:

- An objective is met;
- The consumer is not making progress on an objective after reasonable efforts have been made (and documented) to assist the consumer in making progress (ex. Revising part of the objective; training staff, etc.);
- The consumer (or legal guardian if under 18 or over if the 18 and adjudicated incompetent) requests a change to the treatment plan;
- Information needs to be changed (ex. Care or supervision); and/or
- A new goal/objective is recommended.

Amendments must be:

- Approved by the Lead Clinical Staff
- Approved by the consumer (or legal guardian if under 18 or over if 18 and adjudicated incompetent);
- Attached to the treatment plan in chronological order, outlining specific reason for changes made, what specific changes were made to the treatment plan, and the effective date of the change,
- Dated and signed by the Lead Clinical Staff and the consumer.

NOTE: *After the treatment plan has been amended, the Lead Clinical Staff or Life Skills Specialist must insure that all direct support staff responsible for implementing the plan are trained on the revised plan in a timely manner, and before implementation of the revised plan.*

B-15 Records

Consumer Records:

As an initial and on-going responsibility, the Lead Clinical Staff or Life Skills Specialist is responsible for developing and maintaining consumer records in chronological order, which contains:

- Screening Form
- Medical Necessity Statement
- For consumers who receive Level I Service Coordination, a copy of the most current Single Plan (for consumer age 7 years or older), Individualized Family Service Plan (for consumers age 0-3 years), or Family Service Plan (for consumers age 3-6 years), reflecting the need for Rehabilitation Supports. For consumers receiving level II service coordination a copy of the latest single plan should be placed in the record.
- Progress Summary Notes, in chronological order
- Service Notes, in chronological order
- Assessment data
- Treatment Plan
- A legend explaining any abbreviations used
- An index or table of contents must be available which shows how each record is organized.
- Record of reviewers
- Service agreement form (if receiving level II Service Coordination)

Administrative Records:

As an initial and on-going responsibility, the Lead Clinical Staff or Life Skills Specialist is responsible for developing and maintaining administrative records which contains:

- Records of monthly and other direct support staff meetings
- Documentation of direct support staff In-Service Training
- Record of individual case consultations provided by the Lead Clinical Staff or Life Skills Specialist if not recorded in the consumer's case record
- Waiting List for Rehabilitation Supports

- List of Participants

B-16 Service Delivery

For RS I, one unit equals 1-3 hours of treatment plan implementation with at least one hour of face-to-face contact with the consumer (total of 180 minutes of plan Implementation). The LCS or LSS may authorize up to two (2) units of service per day. The second unit of service in a day begins with the fourth hour (181st minute of service) of the treatment plan implementation and continues through the 6th hour (360th minute) of treatment plan implementation. During the second unit, one hour of face-to-face intervention or services with the consumer is required. Example: [Services provided from 1:00pm to 4:00pm would equal one unit if 60 minutes of that time is spent face to face; a second unit could begin at 4:01pm]

The documentation of services on the Progress Summary Note [RS Form 4B] must be completed and filed in the record by the 15th of the month following the month of service delivery.

Staff travel time to and from consumer contact is not included in a unit of service. Treatment Planning or Assessment time is not included in a unit of service. Documentation supports the delivery of one hour of direct service delivery for each unit reported on a calendar day. A maximum of 2 units per calendar day may be provided. A maximum of 250 units per year may be provided.

Note: For consumers eligible for services through the HASCI Division, rehabilitation supports may be provided to those who receive waiver-funded services. [Waiver services cannot be reported at the same time Rehabilitation Supports is reported. For example, if a person is receiving attendant care/personal assistance services through the HASCI Waiver 3 hours per day (8a.m. to 11a.m.) Rehabilitation Supports can only be provided when the attendant/personal assistant is not providing services (after 11 a.m.)]

Note: Consumers may be grouped [no more than four (4) per group] for service delivery when they are family members, or individually select the same activity. Grouping for administrative convenience or social activities is not allowed.

B-17 Waiting Lists for Rehabilitation Supports

The Lead Clinical Staff/Life Skills Specialist is responsible for maintaining a list of consumers served through the HASCI Division and a list of consumers served through the MR/RD or Autism Division who are waiting for Individual Rehabilitation Supports. Individual Rehabilitation Supports Waiting List [RS Form 7] should be used. Each list will allow for a designation of "Urgent Priority" to be used when the consumer's at risk for out of home placement and when the consumer's circumstances present an immediate risk to his/her health or safety.

Each list will allow for a designation of "Urgent Priority" to be used when the consumer's at risk for out of home placement and when the consumer's circumstances present an immediate risk to his/her health or safety, each of these conditions must be present for Consumers to be served from the waiting list in accordance with their "Urgent Priority" status and/or the date each began waiting. The consumer with "Urgent Priority" who has been waiting the longest will be given the first opportunity for services. If no one has been designated as "Urgent Priority", the consumer waiting the longest will be given the opportunity for services. In the event a consumer declines services when offered but desires to continue waiting for Individual Rehabilitation Supports, their date waiting will be changed to the date they declined services.

B-18 Amending the Contract

Contracts are written for specific number of consumers to be served, each to receive up to 250 units of RS/I per fiscal year. (For example, 10 consumers for 2500 units for the year.) When the provider has reported services for the total number of consumers indicated in the contract (example 10), a contract amendment is required to serve another consumer. (For example: A provider reported units of services delivered to ten (10) consumers (contract for 10) the first month of the fiscal year. If during the second month of the fiscal year a consumer terminates from service and a new person requests to be served, the provider must request a contract amendment in order to receive reimbursement for RS I to the new consumer).

The Contract Amendment Request [Form RS Form 5] is submitted to appropriate SCDDSN Central Office staff.

B-19 Rehabilitation Supports Flow Chart

Rehabilitation Supports
Availability of Services Flow Chart